CONFIRMED/SUSPECTED REPORT OF TUBERCULOSIS DISEASE

Department of Public Health & Human Services
TB Program Cogswell Building, Room C-216
1400 Broadway, Helena, MT, 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date: _____
Submitted By: _____
Phone: _____

Patient Name: _____ Age: _____ DOB: _____
City: _____ County: _____ State: _____ Zip Code: _____
Country of Origin: _____ If not USA, month & year of Immigration: _____

Gender: ( ) Female ( ) Male
Race: ( ) White ( ) Native American ( ) Other, specify: _____
Ethnic Origin: ( ) Hispanic ( ) Non-Hispanic

Diagnosis Date: _____ Date first suspected: _____
Site: ( ) Pulmonary ( ) Bone/Joint ( ) Lymph ( ) Miliary ( ) Pleural ( ) Other _____
Re-disease after 12+ months of inactivity: ( ) Yes ( ) No List year of previous diagnosis: _____
Diagnosis reported at time of death: ( ) Yes ( ) No Date expired: _____
Contact of known TB case: ( ) Yes ( ) No Name of case: _____

1. Tuberculin Skin Test Results: Date: _____ mm of Induration: _____
2. X-Ray Results: Date: _____ Results: _____
   Attach X-ray results
3. HIV Results: Date: _____ Results: _____
4. Bacteriological Results: **If state lab is not used, attach lab results. If state lab is used, results are on file.**

Initial Medication Regimen: ( ) INH ( ) RIF ( ) PZA ( ) EMB ( ) Other _____
Date Therapy Started: _____ **DOT Plan**: (dose, freq, location) _____
_____
_____
Brief Clinical History: _____
_____
_____

Resident of Correctional Facility: ( ) Yes ( ) No Facility Name: _____
Resident of Long-term Care Facility: ( ) Yes ( ) No Facility Name: _____
Homeless within the last year: ( ) Yes ( ) No Shelter Name: _____
Occupation: Check all that apply within the past 24 months
( ) Health Care Worker ( ) Migratory Agricultural Worker ( ) Unknown
( ) Correctional Worker ( ) Not employed past 24 months ( ) Other specify: _____

Injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Non-injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Excess Alcohol Use within Past Year: ( ) Yes ( ) No ( ) Unknown

Liver Disease: ( ) Yes ( ) No ( ) Unknown ( ) Hepatitis A, B, or C Type: _____
Diabetes: ( ) Yes ( ) No ( ) Unknown ( ) Type I ( ) Type II
Organ Transplant: ( ) Yes ( ) No ( ) Unknown Transplant Date: _____ Type: _____

Attending Physician: _____ Phone: _____

Public Health Case Manager: _____ Phone: _____